CANYON EYE CENTER
FAMILY VISION CARE

PATIENT INFORMATION

Name _____

Address _____

_____

Phone: Home _____ Cell _____

E-Mail _____

Date of Birth _____

SSN _____ Gender: M / F

Marital Status: Married / Single / Widowed / Divorced

Race: Caucasian / Hispanic / African American / Asian

Ethnicity: Hispanic / Non-Hispanic / Declined

Primary Language _____

Responsible party same as patient □ or

Name _____

Address _____

_____

Relationship _____

Date of Birth _____ SSN# _____

Primary/Family Dr _____

Referring Dr _____

Preferred Pharmacy _____

Date _____

Employer _____

Phone _____

Emergency Contact _____

Phone _____

PRIMARY INSURANCE

Insurance Company _____

Policy # _____ Group # _____

Policy Holder same as patient □ or

Name _____

Address _____

_____

Date of Birth _____ SSN# _____

SECONDARY INSURANCE

Insurance Company _____

Policy # _____ Group # _____

Policy holder same as patient □ or

Name _____

Address _____

_____

Date of Birth _____ SSN# _____

REFRACTION POLICY - I hereby affirm that I have been informed and understand that the doctor may order a refraction for me for either medical reasons or to provide me with a prescription for eyeglasses or contact lenses. I understand that my insurance company may exclude this procedure from my benefits. If this is their policy, I understand and agree that I may have to pay $45.00 out-of-pocket for the refraction with or without a prescription.

HIPAA DISCLOSURE - Under federal law, your patient health information is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

We use health information about you for treatment, to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose your PHI without your permission. In other situations, we will ask for your written authorization before using or disclosing any identifiable PHI.

A complete written copy of our Privacy Practice Policy is available. Please let the receptionist know if you would like a copy to read before signing below.

_____ I have received a copy of the Canyon Eye Center privacy policy.
_____ I do not wish to receive a copy of the Canyon Eye Center privacy policy.

FINANCIAL RESPONSIBILITY - I agree to be personally responsible and fully responsible for payment for services rendered in accordance with any insurance benefits where applicable. I understand that I am financially responsible for charges not covered by my plan or for claims denied because of my failure to comply with conditions set by my insurance carrier. These conditions may include but are not limited to: failure to make co-payment or obtain a written referral for services provided by someone other than my primary care physician. A finance charge of 1-1/2% per month (annual percentage rate 18 %) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

ASSIGNMENT OF BENEFITS – I request insurance benefits for services provided be paid directly to the medical clinic. I verify the accuracy of the above listed demographic and insurance information and I authorize the release of
Any medical information necessary to process payment for services provided.

Signature _____ Date _____

Printed Name of Signer _____

Witness _____ Date _____

Printed Name of Witness _____

3895 West 7800 South, Suite 202, West Jordan, Utah 84088 | phone: 801.948.4442 | fax: 801.987.8462
www.canyoneyecenterutah.com

CANYON EYE CENTER
FAMILY VISION CARE

CONSENT FOR TREATMENT/DILATION

I voluntarily consent to outpatient care and treatment performed by Dr. Wong and all other health care providers at the Canyon Eye Center. I also consent to routine services, diagnostic procedures, medical treatment, and other services as deemed necessary by the health care providers treating me. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed treatment and to discuss it with my health care provider.

Specifically, one important component of a routine complete eye exam is a dilated examination. Dilating eye drops are used to enlarge the pupils to allow examination of the inside of your eyes. For many types of eye examinations, this is a requirement. Dilating drops will usually cause blurred vision. The length of time that vision will be blurred and the degree to which your eyesight is impaired varies from person to person. It is not possible to predict how much or how long vision will be affected. Driving may be difficult after dilated examination. If you choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Adverse reactions, such as acute angle-closure glaucoma, may be triggered by the use of dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Wong and/or his ophthalmic assistants at Canyon Eye Center to administer dilating drops during the course of my treatment. I understand that these drops are necessary to diagnose my condition. I further understand and acknowledge that I have been warned of the potential risks that dilating drops may have on my ability to drive and will take appropriate steps to reduce this risk by not driving immediately after my eyes have been dilated or by wearing sunglasses while driving.

Signature _____ Date _____

Witness _____ Date _____

CANYON EYE CENTER
FAMILY VISION CARE

3895 W 7800 S Suite 202
West Jordan UT 84088
(801) 948-4442

Information to be used or disclosed

The information covered by this authorization includes:

☐ Medical History	☐ Medical Records	☐ Labs/Visual Fields
☐ Surgery Reports	☐ Summary	☐ Other Doctor Records

Persons authorized to Use or Disclose Personal Health Information:

CANYON EYE CENTER

Dr. Gilbert Wong

Name and relationship of persons to whom information may be disclosed:

_____

_____

_____

Name of Patient _____ Date of Birth _____
(Please Print)

_____ Date _____
Signature of Patient

_____ Date _____
Signature of patient representative (if applicable)

Potential for re-disclosure: Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of the information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

ARBITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 Definitions

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.

D. The term "Patient" or "you" means:
(1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND
(2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
(1) working directly with each other to try and find a solution that resolves the Claim, OR
(2) using non-binding mediation (each of us will bear one-half of the costs); OR
(3) using binding arbitration as described in this Agreement.
You may choose to use any or all of these methods to resolve your Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. Arbitration – Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.

B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
(1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
(2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue / Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Term / Rescission / Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it

B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4(E)).

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement and I have been verbally encouraged to read it and this Agreement. I have had the right to ask questions, I have been verbally encouraged to ask any questions, and I have had all my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 Receipt of Copy I have received a copy of this document.

Provider

Gilbert C. Wong, MD
Canyon Eye Center
3895 West 7800 South, Suite 202
West Jordan, UT 84088

Name of Physician, Group or Clinic

Name of Patient (Print)

By: _____

Signature of Physician or Authorized Agent

Signature of Patient or Patient's Representative (Date)

(06/2011)